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ABSTRACT

In response to a request by Senator John Melcher of the United States Senate Special Committee on Aging, the General Accounting Office (GAO) reviewed legislative proposals designed to protect Medicare enrollees from the financial hardships that often accompany catastrophic illness. The GAO originally examined six legislative proposals introduced into the first session of the 100th Congress, then eventually focused on H.R. 2470 and S. 1127, two bills expected to form the basic structure for the Medicare coverage that the full Congress will consider. The GAO also looked at the aspects of long-term care in S. 454. Following the review, the GAO concluded that H.R. 2470 and S. 1127 would add to the benefits available to the elderly, but that some of the elderly would still be at risk for substantial out-of-pocket health care expenses, especially for long-term care, even if the bills are enacted. This report contains: (1) a statement of the GAO objectives, scope, and methodology used in the review; (2) a review and comparison of H.R. 2470 and S. 1127 against the current Medicare program with respect to benefits to enrollees, their costs, and the program's financing mechanisms; (3) a discussion of important issues that may still need attention; and (4) a synthesis of the lessons learned from the operation of state-financed insurance programs for catastrophic illness that the Congress might consider in the development of a federal program. Fifteen tables are included. (NB)

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United States General Accounting Office

GAO

Briefing Report to the Chairman, Special Committee on Aging, U. S. Senate

July 1987

MEDICARE

Catastrophic Illness Insurance

ED 293 035

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United States
General Accounting Office
Washington, D.C. 20548

Program Evaluation and
Methodology Division

B-227664

July 31, 1987

The Honorable John Melcher
Chairman, Special Committee
on Aging
United States Senate

Dear Mr. Chairman:

On January 20, 1987, you asked us to provide you with information about legislative proposals to protect Medicare enrollees from the financial hardships that often accompany catastrophic illness.

Initially, our review focused on six legislative proposals introduced into the first session of the 100th Congress. During the course of our review, the House Ways and Means Committee and the Senate Finance Committee approved H.R. 2470 and S. 1127. It is generally believed that these will form the basic structure for the Medicare coverage that the full Congress will eventually consider.

Therefore, with the concurrence of the committee staff, we focused on H.R. 2470, as approved by the House Ways and Means Committee on May 19, 1987, and S. 1127, as approved by the Senate Finance Committee on May 29, 1987. We also looked at the aspects of long-term care in S. 454, introduced by James R. Sasser.

In response to your request, we developed the following material:

1. a statement of our objectives, scope, and methodology;

2. a review and comparison of H.R. 2470 and S. 1127 against the current Medicare program with respect to benefits to enrollees, their costs, and the program's financing mechanisms;

3. a discussion of important issues that may still need attention; and

4. a synthesis of the lessons learned from the operation of state-financed insurance programs for catastrophic illness that the Congress might consider in the development of a federal program.

Principal Findings

In 1950, just over 8 percent of the population was 65 years old and older, but in 1980 this percentage was over 11 percent. One of the most

important issues of the late 1980's is how to protect the elderly and their families against the catastrophic expenses they may face when they have acute medical problems or when they need long-term care because of chronic illness and disabling conditions such as stroke and Alzheimer's disease.

Despite benefits from Medicare and private supplements to that program, out-of-pocket expenditures for medical care substantially burden them. This is especially true for nursing home care, for which more than one half of all costs are paid for by patients or their relatives.

Both bills are designed to expand Medicare coverage for acute care. Both are intended to be "budget neutral." That is, the cost of the expanded benefits would be paid for through higher Medicare premiums.

The provisions of the two proposals would significantly increase protection for the enrollees. For example, the bills would increase the number of covered hospital days and alter or eliminate deductibles and coinsurance payments. However, even if one of the current proposals or others similar to them are adopted, some gaps will remain.

The gaps in the Medicare program as they would be modified by H.R. 2470 or S. 1127 would be not in hospital services but in the incomplete coverage of physicians' charges and limited coverage of long-term care at home and in nursing homes. Therefore, it seems clear that the expanded Medicare benefits in either proposal would only partially protect the elderly from catastrophic expenses.

Issues that may require additional consideration are the definition of catastrophic expense, the specific health-care needs of the elderly, prescription drugs, and out-of-pocket expenses for services both covered and not covered by Medicare. We discuss these briefly below.

"Catastrophic expense" can be defined either in absolute terms or relative to income or wealth. Both bills define it absolutely, in the sense that they would limit how much an enrollee would have to pay for specific expenses without regard for individual income. The limit, called the "copayment cap," sets the maximum amount an individual would have to pay, either as deductibles or as coinsurance payments, for a spell of illness.

The lower copayment cap being proposed is $1,043. Approximately 91 percent of the Medicare beneficiaries have historically had copayment

expenses totaling less than $1,000 for services covered by Medicare. This means that under the proposed legislation, 91 percent of the enrollees who apply for benefits would not exceed the $1,043 cap (if past trends were to continue) and, therefore, would not be eligible for benefits.

Both Medicare and private insurance (called "Medigap" policies) are designed to deal largely with the cost of acute-care needs and do not cover the typical needs of patients in long-term care, who by and large do not require the services of a physician or a skilled nurse but, rather, need help in dressing, eating, toileting, moving from one place to another, and supervision. While both H.R. 2470 and S. 1127 would extend the number of days covered in a skilled nursing facility, neither bill addresses the long-term services mentioned above.

The Medicaid program does pay for the most expensive long-term service—nursing home care—but it is so structured that a condition of eligibility for it is the impoverishment of the beneficiaries and their spouses. To obtain Medicaid benefits, a person must be either poor or reduced to poverty in the process of trying to pay for care.

Another issue is out-of-pocket expenses. Although H.R. 2470 and S. 1127 differ slightly, the combined expenses for services partially covered and services not covered by Medicare (excluding expenses associated with long-term care) would leave some elderly persons burdened with out-of-pocket expenses quite large in relation to their income. This would be particularly a problem for the elderly "near-poor" who do not qualify for Medicaid.

Many other important issues are addressed in the version of H.R. 2470 approved by the House Energy and Commerce Committee. They include prescription drugs, protecting the sick person or the spouse from impoverishment, and providing for personal care in the home and respite care. However, your need for an immediate analysis of the basic proposal precluded a full analysis of the amended version of the bill at this moment.

The experience of five states in trying to implement catastrophic illness programs may be relevant to some aspects of the federal proposals. New Hampshire and Rhode Island currently operate state-financed catastrophic illness insurance programs; Alaska, Maine, and Minnesota have operated one at some time since the mid-1970's. We derived several lessons from our review of their programs.

First, some of the states included assets as a factor in eligibility determinations. If assets are not included in determining whether an elderly person should receive the program's benefits, then an illness may be defined as catastrophic and covered by the program when the elderly person may in fact have enough wealth in the form of assets to finance care without serious financial effect on the family. The decision to include assets must be carefully considered also because large out-of-pocket expenses an elderly person pays by selling assets could lead to the impoverishment of the sick person or the spouse.

Second, high costs and rapid cost growth generally characterized the states' programs. Hospital benefits produced the main expense for the programs, from 71 percent of total expenditures in Alaska to 86 percent in Maine.

The states tried to contain the rapid growth in program costs with three basic cost-sharing mechanisms: deductibles, coinsurance, and limits to coverage. Rhode Island also created explicit incentives to the elderly to take private insurance coverage. It based a varying deductible on the quality of an applicant's insurance coverage: the more extensive the insurance coverage, the lower the deductible. This is a unique feature of Rhode Island's program, the only program that has been able to maintain hospital benefits. Providing expanded hospital benefits cost the state programs more than providing any other benefit.

The experience of the states indicates the need for continual attention to the ways in which current administrative structures could be used to implement a program and to identify and limit its costs. Administrative costs seem to be reduced to the extent that a program employs existing agencies and resources. Probably the most important lesson from the states' experiences is that the states often had to reassess the relative costs and revenues of their programs.

Summary

Overall, our review indicates that H.R. 2470 and S. 1127 would certainly add to the benefits available to the elderly. However, some of the elderly would still be at risk for substantial out-of-pocket health-care expenses, especially for long-term care, even if these bills are enacted.

For further information, please call me or Carl Wisler at (202-275-1854).

Sincerely,

Eleanor Chelimsky
Director

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Abbreviations

CBO	Congressional Budget Office
HHS	U.S. Department of Health and Human Services
SNF	Skilled nursing facility

Objectives, Scope, and Methodology

The Chairman of the U.S. Senate Special Committee on Aging asked us to review alternative legislative proposals for providing insurance against the expenses of catastrophic illness—a House of Representatives bill, H.R. 2470, originating in the House Ways and Means Committee, and a Senate bill, S. 1127, originating in the Senate Finance Committee.[1] Our overall goal in this report is to present factual information about the bills and the context in which such legislation would operate.

Objectives

Our review focuses on the following broad questions:

1. How do the House and Senate bills to provide insurance against catastrophic illness for Medicare enrollees compare with regard to benefits for enrollees, costs to enrollees, and financing mechanisms?

2. What important issues should be addressed in the development of a federal insurance program for catastrophic illness for the elderly?

3. What lessons learned from the operation of state insurance programs for catastrophic illness might the Congress consider in the development of a federal program?

Scope

The two legislative proposals, both designed to expand insurance for Medicare enrollees, provide the basic structure for a federal insurance program for catastrophic illness as it is being addressed by the 100th Congress. We have compared the two proposals to each other and to the existing Medicare program.

[1]H.R. 2470, the Medicare Catastrophic Protection Act of 1987, was reported out of the House Ways and Means Committee on May 27, 1987, and referred to the House Committee on Energy and Commerce, Subcommittee on Health and the Environment. As amended by the House Committee on Energy and Commerce, H.R. 2470 was reported to the House on July 1 and approved on July 22, 1987. S. 1127, the Senate's Medicare Catastrophic Loss Prevention Act of 1987, was approved by the Senate Finance Committee on May 29, 1987, and reported on July 27, 1987. For a brief discussion of several other bills introduced in the 100th Congress, see U.S. General Accounting Office, Medicare: Comparison of Catastrophic Health Insurance Proposals, GAO/HRD-87-9BR (Washington, D.C.: June 1987). Except where noted otherwise, our discussion of H.R. 2470 is based on the bill as reported by the Committee on Ways and Means and our discussion of S. 1127 is based on the bill approved by the Senate Finance Committee. We do discuss subsequent legislative actions relevant to the bills in the final section of appendix II.

Although much of our discussion is focused on the elderly because they are the largest group covered by Medicare, we refer also to disabled persons and persons afflicted with end-stage renal disease when they would be especially affected by proposed legislative changes.[2]

Our review is further focused by concentrating on (1) major areas of difference between the House and Senate bills and (2) some additional controversial topics, some of which are included in both bills and some in neither. Whether or not the proposals are in fact "budget neutral" is a question that is outside the scope of our work.

Our analysis of lessons learned from the states is drawn from the experiences of all the states that have had insurance programs for catastrophic illness since 1975: Alaska, Maine, Massachusetts, Minnesota, and Rhode Island.

Methodology

To answer our evaluation questions, we carried out the four following steps.

Step 1

We began with a review of current literature. Computerized searches yielded approximately 600 references, which we screened. The items that appeared to be most relevant to our evaluation questions constituted a preliminary bibliography of 225 citations. To identify other references that we might have missed in the computerized search, we mailed the bibliography to 114 persons and organizations—state and federal governments, colleges and universities, private research organizations, the insurance and health care industries, and organizations representing the elderly. Deletions we made plus the additions suggested by the experts brought our final bibliography to 173 references.

Step 2

We compared the two catastrophic illness insurance bills with each other and with the current Medicare law with respect to their benefits and costs for enrollees and the financing mechanisms for the program.

[2]Medicare covers three major subpopulations that included 31.1 million persons on July 1, 1985: (1) beneficiaries 65 years old and older (28.2 million), (2) disabled beneficiaries younger than 65 (2.9 million), and (3) persons entitled to Medicare benefits solely because of end-stage renal disease (31,000).

Step 3

We interviewed experts in the field in order to identify the important, unresolved, and controversial issues in providing catastrophic illness insurance for the elderly. For further factual information about these issues, we reviewed the literature, statistical data bases, and the provision for long-term care in S. 454, introduced by James R. Sasser.

Step 4

To identify lessons learned about catastrophic illness insurance programs, we analyzed the experiences of the five states named above. We reviewed the literature available on these programs and interviewed state officials and other experts for their views about how the programs operated.

Proposed Changes in Benefits, Costs, and Financing Mechanisms

We compared the current Medicare law, H.R. 2470, and S. 1127 across three critical dimensions: benefits to enrollees, costs to enrollees, and financing mechanisms.

Proposed Changes in Benefits for Enrollees

Under the present Medicare law, benefits fall into two categories. Hospital insurance (under Medicare Part A) covers inpatient care, short-term skilled nursing facility (SNF) care, intermittent home health care, and hospice care. Other benefits are grouped under supplementary medical insurance (under Medicare Part B), which covers outpatient services, physicians' services, laboratory services, and a small amount of home health care.

The benefit changes associated with H.R. 2470 and S. 1127 are summarized in table II.1. Below, we describe some of the similarities and differences between the two legislative proposals. Tables II.2 and II.3 on page 14 provide estimates of the average amount and distribution of benefits by type of enrollee under the two bills for 1989.

Table II.1: Summary of Current Medicare Provisions and Proposed Changes Under H.R. 2470 and S. 1127

Provision	Current law	H.R. 2470	S. 1127
Part A hospital insurance			
Coverage	Hospital inpatient care, short-term skilled nursing facility (SNF) care, intermittent home health care, hospice care	Same as current law, except for changes noted under benefits	Same as current law, except for changes noted under benefits
Benefits	Hospital inpatient stays up to 90 days per "spell of illness" plus up to 60 "lifetime reserve" days; benefit periods unlimited in number	No limit on hospital inpatient stays except for psychiatric care	No limit on hospital inpatient stays except for psychiatric care
	Lifetime limit of 190 days for inpatient psychiatric care	Inpatient psychiatric same as current law	Inpatient psychiatric same as current law
	SNF stays up to 100 days per "spell of illness" following hospital stay	SNF stays up to 150 days a year; no prior hospitalization required	SNF stays up to 150 days a year; no prior hospitalization required
	Home health care skilled nursing visits up to 8 hours a day for up to 2-3 weeks or longer under unusual circumstances	Home health care up to 35 consecutive days	Home health care up to 21 consecutive days for all enrollees and up to 45 days with prior hospital stay
	Lifetime limit of 210 days for hospice care	No limit on hospice days	No limit on hospice care
Deductibles	First day $580 (in 1989) for first hospital stay in each "spell of illness"	First day $565 (in 1989) for first hospital stay a year	First day deductible $580 (in 1989) for first hospital stay a year if not limited by copayment cap
	Part A indexed to hospital update factor; Part B to Social Security cost-of-living adjustment	Parts A and B indexed to Social Security cost-of-living adjustment	Indexed same as current law
	One deductible for units of blood in each "spell of illness"	One deductible a year for units of blood	One deductible a year for units of blood
Coinsurance	1/4 of the deductible for 61-90 hospital days ($130 a day in 1987) and 1/2 of the deductible for reserve days ($260 a day in 1987)	None for hospital stays	None for hospital stays
	1/8 of the deductible for 21-100 SNF days ($65 a day in 1987)	20% of reasonable SNF costs for first 7 days of each year	15% of reasonable costs for first 10 days of each year
	5% of charges for respite care provided under hospice care	The 5% coinsurance charged for respite care under hospice care counts toward the catastrophic limit	The 5% coinsurance charged for respite care under hospice care counts toward the catastrophic limit
Part B supplemental medical insurance			
Coverage	Physicians' services, outpatient care, laboratory, home health care	Same as current law, except for changes noted under benefits	Same as current law
Benefits	Outpatient prescription drugs for cases such as cataract and first-year transplant patients	Prescription drugs at an undetermined level	Immunosuppressant drugs; requires the Institute of Medicine to study the cost of broader prescription drug coverage
	Reimbursement up to $250 a year for outpatient psychiatric care	Reimbursement up to $1,000 a year for psychiatric care	Reimbursement up to $250 a year for outpatient psychiatric care

(continued)

Provision	Current law	H.R. 2470	S. 1127
		Requires the General Accounting Office to assess the need for and costs of comprehensive long-term care	
Premiums	Flat Part B premium ($22 a month in 1988, $26 a month in 1992)	A new Part B premium of $4 a month in 1988, indexed in subsequent years to increases in the insurance value of catastrophic benefits, plus a supplemental income-related premium for Part B enrollees with tax liabilities for $150 or more	A Part A income-related premium at rates designed to cover benefit costs through 1992 plus a flat Part B premium increase of $1.00 a month in 1990 and an additional $0.40 a month in 1991
Deductible	Annual $75	Same as current law	Same as current law
Coinsurance	20% of reasonable charges above the deductible (50% for outpatient psychiatric services)	Same as current law	Same as current law
Copayment cap	None, no limit on expenses not paid by Medicare	$1,043 (in 1989) includes the annual and the Part B deductible for blood, $250 of the mental health deductible, and 20% coinsurance, indexed to Social Security cost-of- living adjustment	$1,773 (in 1989) includes Part A deductibles and the sum of Parts A and B services; indexed to Social Security cost-of-living adjustment
Medicaid-Medicare link	States may "buy in" to Part B for poor, elderly, and disabled who are eligible for Medicare; federal matching for premiums is available for Medicaid populations eligible for Medicaid cash assistance	Requires Medicare buy-in in all states	Requires states to spend Medicaid savings on the elderly to help prevent impoverishment of spouses
Total estimated benefit costs[a]		$1.06 billion in FY 1988 $4.02 billion in FY 1989 $5.95 billion in FY 1990 $7.15 billion in FY 1991 $8.41 billion in FY 1992 $26.59 billion in FY 1988-92	$1.34 billion in FY 1988 $3.43 billion in FY 1989 $4.73 billion in FY 1990 $5.60 billion in FY 1991 $6.53 billion in FY 1992 $21.63 billion in FY 1988-92
Financing	Part A Social Security payroll tax paid by employers, employees, and the self-employed; Part B, an enrollee's premium of $17.90 a month (in 1987) and federal general revenues	Same as current law plus a supplemental premium paid by all enrollees required to file tax returns, increasing according to adjusted income, and an additional Part B premium of $1.00 a month (in 1990) increasing an additional $0.40 a month beginning in 1991	Same as current law plus a supplemental premium paid by Part B enrollees with income tax liability of $150 or more and an additional catastrophic Part B premium of $4 a month (in 1988) indexed to the insurance value of catastrophic benefits

[a]These estimates represent projected outlays to cover the costs of new program benefits. Both bills are proposed as being budget neutral and as providing for revenues to maintain the solvency of the trust funds.

Source: Adapted from U.S. Congressional Budget Office, "A Comparison of Selected Catastrophic Bills," Washington, D.C., May 27, 1987, p. 3.

Table II.2: Average Projected Benefits Per Enrollee by Family Income and Poverty Status in 1989

Income and status	Current law	Increase in average benefit H.R. 2470	S. 1127
Family income			
Under $10,000	$3,370	$183	$151
$10,000-$15,000	3,395	174	142
$15,000-$20,000	3,111	159	127
$20,000-$30,000	2,809	144	114
$30,000 or more	2,957	147	117
Poverty status			
Poor	$3,337	$201	$167
"Near poor"[a]	3,619	187	153
Nonpoor	2,928	146	115
All enrollees	$3,113	$161	$129

[a]Includes those with incomes above the poverty line but less than 1.5 times the poverty line.

Source: Congressional Budget Office simulations for 1989 using 1985 Medicare claims data adjusted for underreporting. Income information was imputed from the 1984 Health Interview Survey. Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable.

Table II.3: Projected Percentage of Benefits by Type of Enrollee in 1989

Enrollee category	% of enrollees	Benefits received Current law	H.R. 2470	S. 1127
Elderly				
Without renal disease	90.2%	86.4%	74.5%	72.0%
With renal disease	0.1	1.6	5.2	6.5
Disabled				
Without renal disease	9.4%	9.4%	10.5%	10.3%
With renal disease	0.3	2.6	9.5	11.0
All enrollees				
Younger than 65	10.1%	12.4%	20.3%	21.7%
65-69	28.0	20.2	19.0	18.4
70-74	23.4	22.1	20.5	20.2
75-79	17.4	19.1	17.6	17.3
80-84	11.4	13.8	12.1	12.0
85 or older	9.7	12.2	10.1	10.6

Source: Congressional Budget Office simulations for 1989 using 1985 Medicare claims data adjusted for underreporting. Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable.

Similarities in Benefits

Both bills propose to

1. build on the existing Medicare benefit structure;

2. provide for unlimited hospital inpatient stays for general acute care but not psychiatric care;

3. eliminate coinsurance requirements for hospital stays;

4. extend the 210 days of coverage currently allowed for hospice stay to an unlimited number of days[1]

5. extend the coverage of care in skilled nursing facilities from 100 to 150 days;[2]

6. institute a "per year" instead of a "per spell of illness" basis for determining deductible costs for hospital inpatient care, SNF care, and units of blood;

7. provide the greatest increase in benefits to lower-income enrollees—under H.R. 2470, the average increase in benefits is estimated to be $161 but would be $201 for poor enrollees and $146 for nonpoor enrollees, and under S. 1127, the average increase in benefits is estimated to be $129 but would be $167 for poor enrollees and $115 for nonpoor enrollees;

8. distribute 20 to 21 percent of the new benefits to the 10 percent of all Medicare enrollees who are disabled;

9. distribute at least 14 percent of the new benefits to the 0.4 percent of the Medicare enrollees with end-stage renal disease, whether elderly or disabled;

10. finance a majority of the new benefits through a "supplemental premium" that would be collected with income taxes for the estimated 35-40 percent of the elderly who have incomes high enough to incur a tax liability.

[1]H.R. 2470 requires the certification of a physician.

[2]For the 150 days of SNF care under H.R. 2470, beneficiaries would have to pay for the first 7 days of each year at 20 percent of the reasonable costs; under S. 1127, beneficiaries would have to pay for the first 10 days of each year at 15 percent of the reasonable costs.

Differences in Benefits

Important differences between the bills include the following:

1. H.R. 2470 would expand benefits but would also require all higher-income beneficiaries, even if they have only Part A hospital inpatient coverage, to pay a supplemental premium to finance the catastrophic benefits.[3] Benefits under S. 1127 would be completely optional in that only those who enroll in Medicare's Part B program would be eligible for the new catastrophic coverage. About 98 percent of Medicare beneficiaries presently choose Part B coverage.

2. Under H.R. 2470, only the basic Part B premium would remain deductible; under S. 1127, both the supplemental and basic premiums would be deductible.

3. The basic monthly Part B premium under H.R. 2470 would be $24.90 (in 1990); under S. 1127, it would be $29.00.

4. Under H.R. 2470, a single elderly person with an income of about $19,000 would be assessed the top supplemental premium of $580, but under S. 1127, this person would pay a supplemental premium of $108. The premium would be $580 under the Senate bill if income were between $42,000 and $52,000, and it would be capped at $800 for persons with higher incomes.

5. The bills also differ in their treatment of the so-called "windfall" that the states would receive when Medicare, an all-federal program, begins to pick up some of the costs now borne by the Medicaid program. The financing of that program, which provides health coverage to 23.5 million poor people, is split between the federal and state governments. Under both proposals, some health-care expenses of the poor paid for by Medicaid would in the future be paid for by Medicare.[4] However, under H.R. 2470, the states would be required to use the consequent "windfall" money to pay all Medicare premiums, deductibles, and copayments for elderly persons whose incomes are below the federal poverty line

[3]One of the bill's authors, Willis D. Gradison, Jr., terms this supplemental premium "an income-related mandatory user's fee."

[4]The federal government pays an average of 55 percent of Medicaid costs. The Congressional Budget Office (CBO) estimates that because Medicare will pick up some of the expenses currently paid by Medicaid through the mandatory "buy-in" provision, the federal government will save an estimated $55 million in Medicaid expenses in 1988, $200 million in 1989, and $410 million in 1992.

but above the threshold for Medicaid eligibility.[5] S. 1127 would direct the states to use the "windfall" money either to expand Medicaid to cover more low-income elderly persons or to protect spouses of long-term nursing-home residents from poverty. Protection for spouses would be accomplished by raising the income and asset limits that must not be exceeded if the costs of long-term care are to be covered by Medicaid.

6. H.R. 2470 provides for a prescription drug benefit that the bill leaves undetermined. S. 1127 would partially cover one group of costly outpatient prescription drugs: the bill would allow patients with organ transplants to count the cost of immunosuppressant drugs toward the Part B copayment cap. (See the discussion below on how the proposed cap would work.)

Discussion

Both H.R. 2470 and S. 1127 provide for many of the services generally associated with hospital care for acute illnesses and with services for transitional care such as skilled nursing facilities and home health care, which are sometimes required immediately after a patient's release from a hospital. Both proposals offer a limited expansion of Medicare's coverage of transitional care.

Recent evidence indicates that the average hospital stay has been growing shorter, largely because of efforts to contain hospital costs. The frequency of hospital admissions has declined as well. This move toward fewer admissions and earlier discharges may mean that elderly patients will need still more long-term care in the home or in a nursing home.[6] We discuss long-term care further in appendix III.

Both proposals offer some relief to the elderly who are most likely to accumulate catastrophic illness expenses—the poor and "near-poor"—by the manner in which the bills distribute benefits among income groups and by their Medicaid "buy-in" provisions. Both take advantage of the Medicaid "windfall" to reduce the threat of catastrophic expenses for persons who are poor and elderly.

[5]The states are to "buy in" to Part B of Medicare for both their cash-assistance and noncash-assistance Medicaid population who are eligible for Medicare. Federal matching for premium payments is available only for the cash-assistance group. If a state does not buy in for Part B coverage, it cannot receive federal matching payments for medical services that would have been covered under Medicare if there had been a buy-in agreement.

[6]See U.S. General Accounting Office, Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient, GAO/PEMD-86-10 (Washington, D.C.: June 2, 1986).

Proposed Changes in Cost to Enrollees

Under the current law, all Medicare beneficiaries have out-of-pocket costs in one or more of three categories. (1) Persons not automatically covered under Part A pay premiums for Part A coverage and for the optional Part B coverage. (2) Deductible payments are initial charges a beneficiary pays for hospital inpatient care, supplemental medical insurance benefits, and units of blood under Parts A and B before Medicare coverage applies. (3) Coinsurance payments are percentages of total charges for hospital care, skilled nursing facilities, outpatient mental health services, and hospice benefits applied after the deductible has been accounted for. In our discussion, the term "copayment" includes deductible and coinsurance payments.

A beneficiary pays for these costs plus the cost of services not covered by Medicare, either directly out-of-pocket or indirectly by paying for a Medigap plan. A Medigap plan is private insurance designed primarily to fill in the deductible and coinsurance costs for Medicare; such policies typically use the same definitions and rules about allowable charges as Medicare.

The elderly may incur health care costs that are not paid for by Medicare or Medigap policies. Instances include premiums for Medigap insurance policies and the costs of services that exceed Medicare and Medigap limits, as when a patient exceeds the number of hospital days currently allowed by Medicare. Balance-billing is another cost that entails payments to physicians who charge more than Medicare's allowed limits and therefore send a bill to a patient for the "balance" of the fee. We do not discuss any of these costs in this report.

Premiums

Under current law, the Part B flat premium will be $22 monthly in 1988, rising to $26 monthly by 1992. This premium, which is paid only by persons who choose to enroll in Part B, would be continued under both H.R. 2470 and S. 1127. (See table II.4.)

Table II.4: Projected Premiums Per Enrollee in 1988-92

Legislation	1988	1989	1990	1991	1992
Current law					
Flat premiums					
Monthly	$22.00	$22.90	$23.90	$24.90	$26.00
Annual	264.00	274.80	286.80	298.80	312.00
Income-related premiums: maximum annual liability	0	0	0	0	0
H.R. 2470					
New flat premiums					
Monthly	$0	$0	$1.00	$1.50	$1.50
Annual	0	0	12.00	18.00	18.00
Income-related premiums: maximum annual liability	580.00	699.00	777.00	862.00	958.00
S. 1127					
New flat premiums					
Monthly	$4.00	$4.40	$5.10	$5.80	$6.60
Annual	48.00	52.80	61.20	69.60	79.20
Income-related premiums: maximum annual liability	800.00	850.00	900.00	950.00	1,000.00

Source: Congressional Budget Office, "A Comparison of Selected Catastrophic Bills," Washington, D.C., May 27, 1987.

Both proposals would add new premiums. Under H.R. 2470, all Part B enrollees would pay, in addition to the existing annual premium, another flat premium of $1 beginning in 1990. In 1991 and 1992, the additional flat premium would be $1.50 monthly. Under S. 1127, the additional flat premium would be $4 a month in 1988, and by 1992, it would rise to $6.60 a month.

Under both proposals, enrollees with taxable income would be subject to an income-related premium. The maximum premium for any enrollee under H.R. 2470 would be $580 annually in 1988 but would rise to $958 in 1992. Thereafter, the maximum would be indexed to the rate of growth in the subsidy value of Medicare benefits.[7] Under S. 1127, the maximum income-related premium would be $800 in 1988, and this would increase to $1,000 in 1992.

Deductibles

Under H.R. 2470 and S. 1127, beneficiaries would be liable for an annual deductible for Medicare Part A ($520 in 1987). However, the Part A deductible would count toward a copayment cap only under S. 1127.

[7]"Subsidy value" for each enrollee is defined as half the value of Part A hospital insurance benefits plus the excess of the average Part B supplementary medical insurance benefit over the amount of flat premiums the enrollee pays.

Under current law, the hospital deductible is indexed to the annual cost of hospital care, which has historically increased faster than the general cost of living. Under H.R. 2470, the Part A deductible would be indexed to the cost-of-living adjustment, but under S. 1127, it would continue to be indexed as it is now.

Under H.R. 2470, the Part A deductible would rise from $541 in 1988 to $641 in 1992. Under S. 1127, it would rise from $544 in 1988 to $700 in 1992.

Under H.R. 2470 and S. 1127, beneficiaries would continue to be liable for the current $75 deductible for the services covered under Part B.

Both H.R. 2470 and S. 1127 provide that under Parts A and B there would be only one deductible for units of blood per year and that it would count toward the copayment cap.

Coinsurance

The current 20-percent coinsurance charge for services covered by Part B would be continued under H.R. 2470 and S. 1127.

Under current law, the SNF coinsurance rate is one eighth of the hospital inpatient deductible for each day after the 20th and before the 101st of SNF services furnished during a "spell of illness." For 1987, this is $65 a day. Under current law, the rate will rise to $68 in 1988 and $87.50 in 1992. Under H.R. 2470 and S. 1127, SNF coinsurance rates would be keyed to reasonable costs per day, resulting in a daily coinsurance payment of $23.50 or $17.50, respectively, in 1988 and of $30 or $22.50 in 1991.

Under H.R. 2470 and S. 1127, the current coinsurance requirement for respite care provided as part of hospice care would be maintained but would count toward the copayment cap.

Copayments

Reductions in copayment costs under the House and Senate proposals would be largest for lower-income groups. In this section, we summarize estimates of how the bills would distribute costs among enrollees.

Under current law, 9.4 percent of the enrollees in Medicare will pay more than $1,500 in copayment costs in 1989. Under H.R. 2470, 6.7 percent of the enrollees would incur copayment costs of more than $1,500. Under S. 1127, slightly more than 8 percent would incur copayment

costs of more than $1,500, and a very small number of those who pay only hospital insurance under Part A (who are not protected under this bill) would incur copayment costs of $3,000 or more. (See table II.5.)

Table II.5: Projected Percentage Distribution of Enrollees by Copayment Costs in 1989

Copayment costs per enrollee	Current law	H.R. 2470	S. 1127
$0	3.2%	3.2%	3.2%
$1-$100	39.2	39.2	39.2
$101-$200	22.3	22.2	22.2
$201-$500	7.7	7.5	7.5
$501-$1,000	10.9	11.8	11.5
$1,001-$1,500	7.3	9.3	8.3
$1,501-$2,000	3.9	6.7	8.1
$2,001-$2,500	2.0	[a]	0
$2,501-$3,000	1.2	0	0
$3,001 or more	2.3	0	[a]
Total	**100.0%**	**100.0%**	**100.0%**

[a]Less than 0.05 percent.

Source: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989. Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable.

Both H.R. 2470 and S. 1127 would establish a cap on copayments but with different limits. (See table II.6.) Under H.R. 2470, the cap would apply to Part B only; under S. 1127, it would apply to Part A and Part B. In both, the cap would be indexed to the cost-of-living adjustment.

Table II.6: Projected Deductibles and Coinsurance Per Enrollee in 1988-92

Legislation	1988	1989	1990	1991	1992
Current law					
Hospital deductible	$544.00	$580.00	$620.00	$660.00	$700.00
Reasonable SNF cost per day	118.00	126.00	134.00	141.00	149.00
SNF coinsurance per day	68.00	72.50	77.50	82.50	87.50
Copayment cap	[a]	[a]	[a]	[a]	[a]
H.R. 2470					
Hospital deductible	$541.00	$565.00	$589.00	$614.00	$641.00
Reasonable SNF cost per day	118.00	126.00	134.00	141.00	149.00
SNF coinsurance per day	23.50	25.00	27.00	28.00	30.00
Copayment cap[b]	[a]	1,043.00	1,089.00	1,136.00	1,185.00
S. 1127					
Hospital deductible	$544.00	$580.00	$620.00	$660.00	$700.00
Reasonable SNF cost per day	118.00	126.00	134.00	141.00	149.00
SNF coinsurance per day	17.50	19.00	20.00	21.00	22.50
Copayment cap[c]	1,700.00	1,773.00	1,851.00	1,931.00	2,014.00

[a]Not applicable

[b]Cap would apply only to Part B copayments

[c]Cap would apply only for the last half of 1988.

Source: Congressional Budget Office, "A Comparison of Selected Catastrophic Bills," Washington, D.C., May 27, 1987. Under both the House and Senate proposals, average copayment costs would be reduced. The average 1989 cost reduction for an enrollee would be $136 under H.R. 2470 and $115 under S. 1127.

Under H.R. 2470, 1 percent of the enrollees would face an increase in copayment costs in 1989 that would vary from a few dollars to more than $1,000. (See table II.7.) About half the enrollees' whose copayment costs would be reduced would do so because of a $15 reduction in the hospital deductible.

Table II.7: Projected Percentage Distribution of Enrollees by Change in Copayment Liabilities in 1989

	% of enrollees	
	H.R. 2470	S. 1127
Decrease		
$1-$250	15.0%	1.1%
$251-$500	1.3	0.8
$501-$1,000	3.5	3.0
$1,001-$2,000	1.9	1.5
$2,001-$3,000	0.6	0.5
$3,001 or more	41.0	0.9
Total	**23.3%**	**7.8%**
Increase		
$1-$250	0.3%	0.3%
$251-$500	0.1	0.1
$501-$1,000	0.6	0.6
$1,001-$2,000	a	0
$2,001-$3,000	0	0
$3,001 or more	0	0
Total	**1.0%**	**1.0%**
Average change	$−136	$−115

[a]Less than 0.05 percent.

Source: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989. Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable.

Under H.R. 2470, the reduction in the average copayment costs would be greater in 1989 for the poor, at $174, than for the nonpoor, at $122. Under S. 1127, the change would be in the same direction—a $150 reduction in costs for the poor and $102 for the nonpoor. (See table II.8.)

Table II.8: Average Projected Change in Copayment Costs Per Enrollee by Income and Poverty Status in 1989

Income and status	Current law	Change H.R. 2470	Change S.1127
Family income			
Under $10,000	$568	$−160	$−136
$10,000-$15,000	562	−148	−126
$15,000-$20,000	524	−134	−113
$20,000-$30,000	479	−119	−100
$30,000 or more	499	−122	−102
Poverty status			
Poor	$570	$−174	$−150
"Near poor"[a]	592	−160	−137
Nonpoor	496	−122	−102
All enrollees	**$524**	**$−136**	**$−115**

[a]Includes those with incomes above the poverty line but less than 1.5 times the poverty line.

Source: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989. Income information was imputed from the 1984 Health Interview Survey. Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable.

Under H.R. 2470, 23 percent of the enrollees would see their copayment costs fall by amounts ranging from a few dollars to more than $3,000. Under S. 1127, almost 8 percent of the enrollees would see their copayment costs fall similarly. Seventy-six percent under H.R. 2470 and 91 percent under S. 1127 would experience no change in copayment costs.

The proportion of enrollees for whom some portion of current copayment costs would be assumed by Medicare would be 8.1 percent under H.R. 2470 or 5.7 percent under S. 1127. (See table II.9.)

Table II.9: Projected Benefits and Copayments Per Enrollee in 1989

	Current law	H.R. 2470	S. 1127
Average benefit relative to current law	$3,113	$3,273	$3,242
Change		1.05%	1.04%
Change in average benefit	0	$161	$129
Average copayment relative to current law	$524	$388	$410
Change		26%	22%
Enrollees affected by copayment cap[a]	0	8.1%	5.7%

[a]H.R. 2470 applies only to Part B copayments. S. 1127 applies to Part A and Part B copayments together.

Source: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and projected to 1989. Includes all enrollees in Part A hospital insurance and Part B supplemental medical insurance as applicable.

Discussion

Although less than 9 percent of the Medicare beneficiaries are expected to exceed the lowest proposed copayment cap ($1,043), out-of-pocket hospital expenses can be very high for the few who are in acute-care hospitals for more than 60 days in a year and who are not covered by Medigap insurance.[8] A hospital stay of longer than 60 days requires a payment of $130 a day between 61 and 90 days and $260 a day after 90 days.

In addition, the initial deductible under Medicare ($520 in 1987) must be paid out-of-pocket by the 20 percent of enrollees who have neither Medigap policies nor coverage under Medicaid. The same people must make out-of-pocket coinsurance payments. Under the current law, as a consequence, a Medicare beneficiary can incur almost $19,000 in hospital expenses before Medicare coverage runs out. This means that families may incur catastrophic expenses even before reaching the limits of their Medicare coverage. The provisions in H.R. 2470 and S. 1127 that would eliminate or alter the current provisions on deductible and coinsurance charges and limits for hospital inpatient and hospice stays could provide some financial relief from copayment costs, particularly for the poor and "near-poor."

If the essential features of either bill were to become law, the major gaps remaining in Medicare would be not in the coverage of hospital expenses but in the limited coverage of Part B physicians' charges and coverage of certain very important items such as long-term care and prescription drugs.[9]

Under Part B, an enrollee must pay a $75 deductible before any reimbursement is provided. After paying the deductible, the Medicare enrollee is reimbursed for 80 percent of an "allowable" charge but not for balance-billing by the physician. Thus, in some instances the real payment not covered by Medicare may be not 20 percent of the physician's charge but significantly more.

To avoid out-of-pocket payments for deductible and coinsurance costs, 65 percent of all Medicare enrollees buy supplementary plans in the form of private insurance (another 10 percent are eligible for Medicaid).

[8]According to the Health Care Financing Administration, less than 1 percent of the Medicare beneficiaries each year stay in the hospital longer than 60 days and therefore incur the additional Medicare coinsurance fees.

[9]See our report entitled Medicare: Prescription Drug Issues, PEMD-87-20 (Washington, D.C.: July 16, 1987).

These Medigap policies are an additional expense for the elderly. For the 80 percent of Medicare beneficiaries who carry them, they provide limited coverage for prescription drugs and other charges beyond what Medicare reimburses. They do not deal at all with the cost of long-term care.[10]

Medicare Financing Mechanisms

Medicare Part A is financed primarily through Social Security payroll tax contributions paid to a trust fund by employers, employees, and the self-employed. Part B is financed through premiums from its enrollees and from general federal revenues, also paid to a trust fund. The benefits being proposed are intended to be "budget neutral" or "pay-as-you-go," indicating that the bills could be implemented with no cost to the federal government and with small, predictable increases in the beneficiaries' premiums. The program's costs for the new benefits are the difference between outlays, or the money the federal government spends to provide benefits, and revenues, or the money enrollees pay to the government as premiums. In a "budget-neutral" bill, the costs would be zero.

Some details on the financing mechanisms and the costs of H.R. 2470 and S. 1127 are as follows:

1. Both proposals would be financed by an additional two-part premium for Part B enrollees. Under H.R. 2470, the additional benefits would be financed through ad hoc increases of $1.00 a month in 1990 and an additional $0.40 a month in 1991. In addition, all taxpayers eligible for benefits under Part A would pay a supplemental income-related premium through the income tax system at a rate designed to cover the remaining costs of benefits through 1992. Under S. 1127, all Part B enrollees would pay a new premium of $4.00 a month in 1988, this premium being indexed in subsequent years to increases in the insurance value of catastrophic benefits. In addition, Part B enrollees with an income-tax liability of $150.00 or more would pay a supplemental income-related premium designed to cover the remaining costs of the new benefits.

2. H.R. 2470 would be the more expensive of the two proposals, totaling $26.6 billion in estimated outlays over the 5-year period from 1988

[10]See U.S. General Accounting Office, Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, GAO/HRD-87-8 (Washington, D.C.: October 17, 1986).

through 1992; outlays for S. 1127 for the same 5-year period are estimated at $21.6 billion.[11]

While the two bills are intended to be "budget neutral," some are concerned that they will not be. In fact, the estimates for S. 1127 show a net cost for the last 3 years. For example, the secretary of the Department of Health and Human Services (HHS), commenting on H.R. 2470, has stated that preliminary estimates indicate that program outlays would exceed revenues and that a shortfall of close to $10 billion would be likely by the year 2000. In addition, 12 members of the House Energy and Commerce Committee presented dissenting views in the committee report on H.R. 2470, stating that the federal government will have to pick up an even greater proportion of the total bill because of outyear limits on premium levels mandated in the legislation.

The Status of the Legislative Proposals

On July 22, 1987, the House of Representatives passed H.R. 2470 by a vote of 302 to 127 as a compromise version of the provisions approved by the Committee on Ways and Means and the Committee on Energy and Commerce.[12] H.R. 2470 covers catastrophic expenses for prescription drugs and personal care in the home. The Part B premiums would be increased to cover the costs of these benefits. Finally, the bill would require the states to add provisions to their Medicaid programs that would protect spouses from impoverishment, limit the transfer of assets in order to qualify for Medicaid benefits, and require the states to pay the Medicare premium, deductibles, and coinsurance costs for Medicaid enrollees eligible for Medicare.

H.R. 2470 as the House passed it provides that a beneficiary's copayment for all physicians' and outpatient services would be limited to $1,043 in 1989. Medicare would pay 80 percent of a beneficiary's outpatient prescription drugs after a $500 deductible. Total out-of-pocket expenditures for hospital, physicians' fees, and other covered benefits except drugs would be limited to $1,800 annually.

[11]CBO's projected outlay estimates include administrative costs. The annual administrative cost has been reported as about 2 percent of total program outlays for Medicare Part A and around 5 percent of total outlays for Part B.

[12]As passed, H.R. 2470 incorporates the text of H.R. 2941. On July 27,1987, the Senate Finance Committee reported S. 1127 to the full Senate. We do not discuss the Senate bill in this section because we do not yet know enough about it.

Dissenting opinions in the Committee on Energy and Commerce report indicate serious concern about the addition of benefits for drugs. Opponents of the provision point out that many Medicare beneficiaries already pay for private Medigap policies that provide drug coverage and do not want to pay an additional premium for drugs that becomes effective only after a $500 deductible has been met.

There are some wide disparities in the outlay estimates for the provision on drugs. On the one hand, CBO estimates that the outlay for this benefit would be approximately $965 million in fiscal year 1989. On the other hand, HHS estimates that it would cost between $7 billion and $9 billion in its first year, stating further that even if the bill is finally enacted, the provision could not be managed through Medicare, because of tremendous administrative problems, until January 1989 or perhaps even 1990.[13]

H.R. 2470 as the House passed it would be financed by premiums. A Part B flat premium added to the current law would cost beneficiaries $2.60 per month in 1989 and rise to $5.50 by 1992. In addition, enrollees would pay an additional income-related premium of about 7 percent on their gross income in excess of $6,000 a year per person, to a maximum of $580 in 1988 for those with incomes over $15,000. The maximum would gradually rise to $1,117 by 1992. The average income-related premium for those subject to it—about 40 percent of the Medicare enrollees—would be $155 a year in 1988 and $271 in 1992.

H.R. 2470 also requires state Medicaid programs to pay all Medicare premiums, coinsurance payments, and deductibles for elderly and disabled Medicare beneficiaries below the poverty line.

Another major provision would prevent the spouse of a person who goes to a nursing home from having to be impoverished before Medicaid assumes the financial burden. The bill also provides for up to 80 hours a year of home health aid and personal care services for chronically dependent homebound persons.

Other benefits include unlimited hospital inpatient acute care, increasing the maximum number of consecutive days of allowed home health care to 35, increasing the limit on Medicare payments for outpatient mental health care from $250 a year to $1,000, and extending hospice care beyond 210 days.

[13]It is unclear if the "costs" HHS is referring to are program outlays or the difference between outlays and revenues.

Important Issues

Beyond our discussion in appendix II, a number of issues may still need attention. In this appendix, we discuss five of the more important ones.

1. the definition of "catastrophic expense,"

2. the health-care needs of the elderly,

3. long-term care,

4. prescription drugs, and

5. out-of-pocket costs for Medicare beneficiaries.

As noted earlier, the issue of whether the various proposals are "budget neutral" is outside the scope of our work.

The Definition of "Catastrophic Expense"

By one definition, a catastrophic expense is a person's annual out-of-pocket medical expense that exceeds a certain dollar amount. An insurance plan may protect an enrollee against catastrophe by paying expenses that exceed the limit. Medicare currently has no limit on out-of-pocket expenses—no copayment cap, in insurance terms—so that costs continue to accumulate. There is no protection against catastrophic expense.

H.R. 2470 and S. 1127 both provide catastrophic protection by setting copayment caps and insuring that Part B enrollees will not have out-of-pocket payments for specific categories of expense that exceed the cap. However, this is only one of several possible definitions and it tends to be hard on the elderly who are poor or "near-poor."

Research has shown that it is important to distinguish between illnesses that are high in cost and those that are financially catastrophic. They overlap but are not identical, as table III.1 illustrates.

Table III.1: A Matrix of Costs, Third-Party Coverage, and Financially Catastrophic Expenses

	Financially catastrophic		Not financially catastrophic	
Costs	**Covered by third party**	**Not covered by third party**	**Covered by third party**	**Not covered by third party**
High	A	B	C	D
Not high	E	F	Neither high nor catastrophic	Neither high nor catastrophic

Source: L. Wyszewianski, "Financially Catastrophic and High-Cost Cases: Definitions, Distinctions, and Their Implications For Policy Formulation," Inquiry 23 (Winter 1986), 384

- Block A represents high-cost cases that are also financially catastrophic because Medigap coverage is inadequate and other resources are insufficient to cover costs.
- Block B represents high-cost cases that are financially catastrophic because there is no Medigap coverage and other resources are inadequate.
- Block C represents high-cost cases that are not catastrophic because the combination of Medigap coverage and other resources is adequate to cover expenses.
- Block D represents high-cost cases that are not catastrophic because, although there is no Medigap coverage, the other resources alone cover expenses.
- Block E represents cases that are not high in cost but are catastrophic because the combination of Medigap coverage and other resources is inadequate even for small expenses.
- Block F represents cases that do not have high cost but are catastrophic because there is no Medigap coverage and resources are inadequate to pay for even small expenses.

A major concern about the definition of catastrophic expense in the legislative proposals before the Congress is that, on the one hand, they would provide coverage for expenses for which many Medicare enrollees already have Medigap coverage while, on the other hand, they tend to ignore that the limited financial resources of other enrollees prevent them from paying out-of-pocket costs. A number of experts have proposed an alternative definition in which out-of-pocket expenditures are catastrophic relative to a family's or an individual's income, such as expenses greater than 5 percent or 10 percent of annual income.[1] The

[1]See S. E. Berki, "A Look at Catastrophic Medical Expenses and the Poor," Health Affairs, 5:6 (Winter 1986), 138-45, and J. Feder, M. Moon, and W. Scanlon, "Catastrophic Health Insurance for the Elderly: Options and Impacts," Georgetown Health Policy Associates, Washington, D.C., July 1987.

choice between an absolute definition of catastrophic expense and a relative one may affect whether the poor and the "near-poor" can fully benefit from the protection offered.

Health Care Needs of the Elderly

The acute medical problems of the elderly receive considerable coverage in the current Medicare program, and the coverage would be substantially expanded by the House and Senate proposals. However, the elderly have other health needs that can lead to catastrophic expenses and that are not presently covered either by Medicare or by these bills.

Advances in medical technology have made life expectancy onger for both the elderly and the disabled. (See table III.2.) With age comes a greater association with chronic illness and the need for continuing health care, including the need for long-term care. In 1984, 72 percent of the Medicare enrollees had some type of supplemental health insurance in addition to their Medicare coverage. But 20 percent were covered only by Medicare and another 8 percent had only Medicare and Medicaid insurance coverage. (See table III.3.) This population tends to be low in income, poor in health, older than average, and therefore greatly at risk for catastrophic out-of-pocket costs.

Table III.2: Size of the Elderly Population 1900 to 2020[a]

Year	Total U.S. population	Age 65 and over	
		Number	Percent
1900	76,303	3,084	4.0
1950	150,697	12,270	8.1
1980	226,505	25,544	11.3
2000	267,955	34,921	13.0
2020	296,597	51,422	17.3

[a]Population in thousands.

Source: U.S. Department of Commerce, Bureau of the Census, decennial census 1900-80 and projections of the population of the United States by age, sex, and race 1983 to 2020, Current Population Reports, series P-25, no. 952, May 1984. Projections are middle series.

Table III.3: Percentage Distribution of Demographic Characteristics by Insurance Coverage in 1984

Characteristic	Medicare	Medicare and private	Medicare and Medicaid
All enrollees	20%	72%	8%
Family income			
Under $5,000	29%	44%	28%
$5,000-$8,999	30	59	12
$9,000-$14,999	21	76	4
$15,000-$24,999	14	83	3
$25,000 or more	10	87	3
Poverty			
Poor	32%	35%	33%
Not poor	19	77	5
Age			
65-69	17%	78%	5%
70-74	19	73	8
75-79	20	72	8
80 or older	27	61	13
Self-reported health			
Excellent	17%	82%	1%
Very good	19	78	3
Good	20	77	3
Fair	24	70	6
Poor	8	57	15

Source: CBO tabulations from the 1984 Survey of Income and Program Participation and Health Interview Survey.

The lower the family income of Medicare enrollees, the greater their tendency to have only Medicare coverage. This tendency is especially pronounced for those with family incomes of less than $9,000.

In 1984, 65 percent of the poor were covered only by Medicare and Medicare plus Medicaid, compared to 24 percent of the "not poor."

According to Medicare enrollees who have reported on their own health, as their health declines they are more likely to have only Medicare coverage.

Concern about protecting the elderly against catastrophic expenses will increasingly have to be centered not only on the need for acute care but also on long-term care, prescription drugs, custodial services in the

home, and respite services for relatives caring at home for the chronically ill and disabled. We discuss some of these matters in the next section.

Long-Term Care

A national survey conducted in 1985 for the American Association of Retired Persons reported that 79 percent of the general population and 70 percent of the population older than 65 believed that Medicare would cover a long nursing home stay, regardless of the type of care required, and half of those with Medicare and supplemental insurance policies believed that they were covered for long-term care expenditures. Their beliefs are not borne out. Both Medicare and the private supplements are designed to deal largely with the cost of acute treatment and do not cover the needs of typical long-term patients, who by and large do not require the services of a physician or a skilled nurse but, rather, need daily help in dressing, eating, toileting, and moving from one place to another and, for some with mental deterioration, supervision.

Nursing home care is the most expensive kind of long-term care, but it is given very limited coverage under Medicare and private insurance (less than 2 percent from Medicare, less than 1 percent from private insurance). More than half the cost of nursing home care is paid for by patients or their relatives. Forty-four percent of the cost of nursing home care is paid for by Medicaid.

Although exact figures are not available, it is estimated that the cost of a month in a typical nursing facility exceeds $1,000, while the average annual family income of persons older than 65 is approximately $15,000. The Medicaid program is the only one that pays for nursing home care—the most expensive long-term service—but it is structured in a way that requires poverty of the beneficiaries and their spouses as a condition of eligibility. Medicaid's eligibility rules frequently require beneficiaries to "spend down," resulting in the rapid impoverishment of beneficiaries and their spouses.[2] Since few people can independently sustain a year's stay in a nursing home, many who start out paying their own way end up dependent on Medicaid.

[2]Medicaid requires that the elderly or disabled nursing home resident be poor in order to qualify for coverage. It also limits the income that a spouse in a nursing home may make available for the spouse remaining at home. This limit may have the effect of impoverishing the spouse still at home, particularly if the couple's assets are in the name of the spouse in the nursing home.

It is easier to qualify for Medicaid by entering an institution than by staying at home, even though care in the home is sometimes less expensive than care in a nursing home. This means that Medicaid-covered long-term care is received almost entirely in nursing homes. Nevertheless, most long-term care is provided neither in nursing homes nor by professional caregivers. Seventy percent of the people who need long-term care choose to remain in private residences, and about three quarters of these receive all needed assistance from family and friends. Another 20 percent receive help from family, friends, and professional agencies.

James R. Sasser has introduced S. 454, which would incorporate, over a 3-year period, all benefits currently available under Medicare Parts A and B into a new Part C that would provide comprehensive coverage for preventive care and long-term care and for prescription drugs and vision, hearing, and dental care without deductibles or coinsurance payments. Services and benefits under S. 454 would be provided under contract by private organizations such as health maintenance organizations.[3]

For S. 454, the estimated average annual outlays for long-term care (nursing home and home care) between 1986 and 1990, assuming the current system of administration and allocation and no change in the rates of use, is projected to be $41.9 billion.[4] (See table III.4.)

[3]Claude Pepper has introduced H.R. 65, a very similar proposal in the House of Representatives.

[4]These estimates are from "Estimating the Long-Term Care Costs of Medicare Part C: Catastrophic Health Insurance Act of 1987, Results From the Brookings/ICF Long-Term Care Financing Model," prepared by Joshua Wiener and Sheila Murray of the Brookings Institution and David Kennell of ICF, Inc., for the U.S. General Accounting Office, Washington, D.C., June 2, 1987.

Table III.4: Long-Term-Care Federal Expenditures for a Base Case and S. 454 Under Various Induced Demand Assumptions[a]

Year	Base case federal expenditures[b]	S. 454	Increase
No change in use			
1986-1990	$13.476	$41.910	$28.434
1991-1995	16.616	50.948	34.332
1996-2000	22.624	68.335	45.731
2001-2005	26.108	77.580	51.472
2006-2010	31.323	94.055	62.732
2011-2015	35.380	106.766	71.386
2016-2020	39.632	121.930	82.298
Induced demand			
Low estimate[c]			
1986-1990	$13.476	$38.589	$25.113
1991-1995	16.616	46.896	30.280
1996-2000	22.624	62.861	40.237
2001-2005	26.108	71.357	45.249
2006-2010	31.323	86.399	55.076
2011-2015	35.380	98.039	62.659
2016-2020	39.632	112.044	72.412
High estimate[d]			
1986-1990	$13.476	$59.706	$46.230
1991-1995	16.616	72.490	55.874
1996-2000	22.624	96.913	74.289
2001-2005	26.108	110.062	83.954
2006-2010	31.323	132.764	101.441
2011-2015	35.380	150.495	115.115
2016-2020	39.632	172.348	132.716

[a]Expenditures in billions of dollars.

[b]Base case represents what would happen with no changes in the current organization and federal financing of long-term care, which includes expenditures for federal Medicaid, Medicare, Older Americans Act, Social Services Block Grant, and Veterans Administration.

[c]Assumes 90 percent of current nursing home use and 100 percent of current home care.

[d]Assumes 130 percent of current nursing home use and 190 percent of current home care.

Source: Data prepared for U.S. General Accounting Office by the Brookings Institution.

Under S. 454, average annual outlays are projected to be $121.9 billion between the years 2016 and 2020. Average annual administrative costs for 1986-90 would be $5.0 billion. Between 2016 and 2020, the annual average administrative cost would rise to $13.7 billion.

The financing mechanisms for S. 454 include flat premium payments by enrollees and transfers into a new Part C trust fund of revenues that would otherwise be collected under Parts A and B.

The Part C program would be financed through three sources: (1) existing Medicare funds from Parts A and B, (2) the federal share of Medicaid payments for long-term care (since the new Part C program would cover nursing home care, funds presently used for this purpose under Medicaid could be used for Part C), and (3) beneficiaries' premiums. Beneficiaries would pay a premium, in monthly installments, equal to 25 percent of the national average of the capitated payment of providers. For 1986, the annual premium would have been about $800 (or 25 percent of $3,200). Beneficiaries' premiums could not exceed 15 percent of an individual's income and the federal government would pay the difference.

Prescription Drugs

Buying prescription drugs can be a major out-of-pocket expense for the elderly. Millions of the elderly suffering from such chronic conditions as diabetes, high blood pressure, various heart conditions, and some types of cancer depend on medication to help control these problems. From January 1980 through 1986, prescription drug costs rose about 80 percent—2.5 times faster than consumer prices in general. Under current law, Medicare generally pays only for immunosuppressant drugs in the first year following a transplant operation covered under Medicare. The following facts indicate the scope of the prescription drug issue for the elderly and the provisions for prescription drugs in the version of H.R. 2470 approved by the Committee on Energy and Commerce.

More than 75 percent of persons older than 65 use prescription drugs; for the elderly who are chronically ill, this figure is 90 percent.

Persons 65 and older use 30 percent of all prescription drugs used in the United States—approximately three times the rate of the population younger than 65.

The Energy and Commerce version of H.R. 2470 would expand Part B to include 80 percent of reasonable costs for prescription drugs over a $500 deductible in 1989. After 1989, the deductible would be indexed to the medical component of the consumer price index.

The Congressional Budget Office estimates that 5.5 million beneficiaries, or about 17 percent of the Part B enrollees, would exceed the $500

deductible for prescription drugs and, therefore, benefit from the bill in 1989, at an estimated cost of $965 million for the fiscal year.[5]

It is estimated that per capita expenditures on prescription drugs by Medicare enrollees would be $250 in 1988 and increase to $331 in 1992.

The monthly premium increase required by the drug benefit is estimated to be $2.30 in 1989, $3.40 in 1990, $3.80 in 1991, and $4.10 in 1992.

The administrative cost to run the drug benefit portion of the Medicare program is estimated at $90 million for fiscal year 1988 and $135 million by 1992.

The addition of coverage for prescription drugs would significantly reduce out-of-pocket expenditures for beneficiaries. However, the proposed deductible would keep this provision from helping some of the elderly who need it the most—the "near-poor" who do not have private supplementary insurance.

Out-Of-Pocket Costs for Medicare Beneficiaries

Although Medicare beneficiaries' out-of-pocket expenses differ slightly by income under H.R. 2470 and S. 1127, the combined expenses for services partially covered and not covered by Medicare (excluding expenses associated with long-term care) would leave some elderly persons at risk for out-of-pocket expenses quite large in relation to their income. This would be particularly a problem for the elderly who are poor and "near-poor" and whose out-of-pocket expenses exceed 15 or 20 percent of their income.

Even the lowest of the proposed caps in the two bills, $1,043 under H.R. 2470, would require the elderly to spend, on the average, 8 percent of their income for medical care. (See table III.5.)

[5]CBO's assumptions are that the use of prescription drugs would rise only slightly under this proposal because of the large deductible and the fact that drug use is overseen by physicians.

Table III.5: Projected Financial Burdens on the Elderly

Health-care cost	Current law	H.R. 2470	S. 1127
Average			
All elderly	10.0%	8.1%	9.5%
Income less than $10,000	12.4	9.8	11.9
Income more than $10,000	6.7	5.8	6.2
Greater than 15% of income			
All elderly	19.2%	15.8%	18.9%
Income less than $10,000	26.1	22.1	26.1
Income more than $10,000	9.5	7.1	8.9
Greater than 20% of income			
All elderly	13.5%	9.9%	13.1%
Income less than $10,000	18.2	14.5	18.2
Income more than $10,000	6.9	3.6	6.1

Source: Adapted from data prepared by William Scanlon, Ph.D., for Villars Foundation.

The percentage of the elderly whose current private liabilities are greater than 15 percent of their income would decline 3.4 percent under H.R. 2470 and less than 1 percent under S. 1127.[6]

Under H.R. 2470, the percentage of elderly with income less than $10,000 whose private liabilities are greater than 15 percent of their income would decrease 4 percent; under S. 1127, the percentage would be the same as under the current Medicare system. Under H.R. 2470, the percentage of elderly whose income is less than $10,000 and who have copayment costs greater than 20 percent of their income would decline nearly 4 percent; under S. 1127, the percentage would not change.

[6]"Private liabilities" refers to total medical care expenses less what Medicare and other public programs pay.

Lessons Learned From State Programs

Alaska, Maine, Minnesota, New Hampshire, and Rhode Island currently operate or have operated catastrophic illness programs.[1] Rhode Island, which has operated its catastrophic illness program continuously since 1975, and New Hampshire, which has operated its program since 1981, are the only states where programs are still in existence. Alaska and Maine discontinued their programs in July 1987. Minnesota's program operated between 1977 and 1980.

The five state programs were all designed to protect individuals and their families from exceedingly large financial burdens from medical expenses by being "payers of last resort," so that medical bills would be paid by the state programs only after all other sources of third-party coverage, public or private, had been exhausted. Eligibility was and is determined by state residence and uninsured medical bills that exceed set amounts based on income levels, expenses as specified proportions of income, or total wealth, which sometimes included assets and was adjusted for family size. These criteria were incorporated into the formulas for deductibles. Table IV.1 gives some details of the structure of the programs in these states.

[1]New York passed a pilot program in 1978 but did not implement it because the state was unable to obtain federal financial participation under Medicaid.

Table IV.1: State-Financed Catastrophic Illness Programs

Program aspect	Alaska	Maine
Name and effective date	Catastrophic Illness Program (CIP), July 1, 1976-July 1986	Catastrophic Illness Program (CIP), 1975-1987
Eligibility[a]	$10,000 or % of income and assets adjusted by family size	$7,000 and % of income and assets
Annual population	92 with $15,104 mean gross income; 20% are age 51+	432; 90% have income $5,000 or less; 79% have $2,500 or less; 43% have no assets; 34% are age 45-64, 3% 65+
Benefits	Hospital; physician; up to 30 SNF days	Nonpsychiatric physician; up to 60 SNF days prior to hospitalization within 1 week of 5-day hospital stay; prescription drugs; dental from accidents; ambulance; medical supplies and equipment; lab and x-ray
Cost-sharing		
Deductible	$10,000 or 40% of income + (liquid resources − $1,000) + (10% of nonliquid resources), average $14,203 with 3+ years to pay	$7,000 + 30% of net income + 10% of assets
Limit	$50,000	None
Cost		
Total annual	$1,777,800	$172,619[d]
Per case	$18,500	$420
Highest	71% hospital	86% hospital before hospital benefits were eliminated; projected $15,200,000 with hospital
Administration	Department of Health and Social Services staff plus eligibility and benefits committee	Department of Human Services; eligibility determined through local Medicaid and Medically Needy Program offices
Financing	General state revenues	General state revenues; a cigarette tax was designated as a source but not a dedicated account

Minnesota	New Hampshire	Rhode Island
Catastrophic Health Expenses Program, July 1, 1977-1981	Catastrophic Illness Program (CIP), 1981-present	Catastrophic Health Insurance Program (CHIP), 1975-present
% of income that varies by income	One of 5 categories + % of gross income; no minimum below an "allowable" income[b]	% of income; minimum $1,118-$11,118 varies by category and decreases as outside insurance increases
1,156 with $7,690 average income; 88% have $15,000 or less; average age 44; 35% are 50-64, 15.5% 65+	252 low-income; 65.5% are age 22-64, 26% 65+	296 with $12,000 average income; 50% are age 65+
Hospital; physician; up to 120 SNF days within 14 days after 3-day hospital stay; prescription drugs; home health up to 180 days; diagnostic and therapeutic, including lab, x-rays, and physical therapy; transportation for kidney dialysis	Outpatient hospital; physician; prescription drugs; ambulance; other transportation; medical devices[c]	Hospital; physician; prescription drugs; dental from accidents; visiting nurse; ambulance; durable medical equipment; some chiropractic; diagnostic; speech and physical therapy; radiology
20-30% of income; average $1,612	None	5% with Medicare and full private insurance up to 50% without Medicare and no private insurance; average $1,346
None	$3,500 ($1,500 with other coverage or resources)	$250,000 on inpatient psychiatric per fiscal year
$5,844,851	$225,000[e]	$2,570,180
$5,034	$890	$8,043
80% hospital	No data available	83% hospital
Department of Public Welfare; applications processed through local welfare offices	Department of Health and Human Services, Division of Public Health Services	Department of Health until July 1, 1985; now Department of Human Services
General state revenues	General state revenues	General state revenues

[a]The eligibility criteria are the basis for the deductibles.

[b]For example, an "allowable income" for a family of four is $15,500.

[c]Hospital inpatient benefits were eliminated in 1982.

[d]In fiscal year 1986, without hospital benefits, it was $172,619; with hospital benefits, it ranged from $2 million to $5 million.

[e]The state sets this as an upper limit for appropriation.

Source: Adapted from Jack Needleman, Maren Anderson, and Ross Jaffe, State Options for Addressing Catastrophic Health Expense (Washington, D.C.: National Center for Health Services Research, April 1983).

In this appendix, we present the following information about the state programs: how they defined catastrophic expenses, the populations they covered, what they cost the state governments, and how they were and are administered.

The Definition of Catastrophic Expenses

The states defined catastrophic illness in terms of the financial consequences to a family's economic resources. They also usually defined it in terms of an absolute cost that medical expenses must exceed in order to allow eligibility for assistance. This cost was incorporated into the states' formulas for deductibles.

- Each state's eligibility criteria were based on medical expenses relative to income.
- Alaska and Maine considered assets in addition to income. The three other states based eligibility strictly on income. For the Minnesota program, which was terminated in 1980, officials recommended that assets be included if the program were to be resumed.

The decision to include assets is of particular importance for the elderly because, in retirement, a family's income may not accurately reflect its economic resources. If assets are not included in determining whether a program's benefits should be received, then benefits may be given to elderly persons who have enough wealth in the form of assets to finance care without serious financial effect on the family. The decision to include assets must be carefully considered, because large out-of-pocket costs financed by assets could lead to the impoverishment of the sick person or the spouse.

Population

The recipients of state-financed catastrophic illness benefits constitute a small portion of the state's population. Further, adequately targeting the underinsured and not just the uninsured has been difficult. Some states have served the low-income uninsured groups, thus helping the poor and "near-poor." For example, 79 percent of Maine's recipients had yearly incomes of less than $2,500 in 1980.

The proportion of elderly beneficiaries varies quite substantially, from 50 percent of the beneficiaries 65 years old or older in Rhode Island to 3 percent in Maine.

The other states have served populations with somewhat larger incomes. The average income of beneficiaries was $15,000 in Alaska and $12,000 in Rhode Island. This level of income may indicate that the programs were reaching the working underinsured or people who had higher incomes prior to the onset of illness. Almost all Rhode Island's recipients have other insurance, probably because explicit monetary incentives for additional insurance are built into the deductible formulas.

The determination of the eligible population has perhaps not been as well defined as intended. The state programs were intended to provide benefits for both the uninsured and underinsured, but without a built-in incentive to maintain or obtain insurance coverage, the programs often ended up providing coverage mostly for the uninsured. Maine's program is a good example. Originally intending to serve both the underinsured and uninsured, it became a program largely covering all health-care benefits for uninsured people, thus accruing unexpectedly large costs and ultimately increasing the deductible and eliminating hospital benefits because of the costs. Rhode Island, in contrast, has provided incentives for other insurance coverage and has managed to serve the underinsured and to maintain hospital benefits.

The Costs of State Programs

Lessons can be learned from the states about which benefits led to the highest costs, possible cost-control difficulties, and cost-sharing mechanisms.

Hospital benefits produced the main expense for the programs, from 71 percent of total expenditures in Alaska to 86 percent in Maine. The annual expenditures for programs with hospital benefits ranged from more than $1.5 million to more than $5 million. Annual expenditures for programs without hospital benefits ranged from $172,000 to $225,000. Average expenditures per case ranged from $5,000 to $18,000 with hospital benefits and from $400 to $1,000 without hospital benefits.

Cost per case may be quite high, even though a small percentage of the population is served, bringing total annual expenditures to a high level and resulting in limitations on benefits. For example, Rhode Island originally offered unlimited psychiatric hospital coverage but later limited this coverage to $250,000 per fiscal year for the program as a whole.[2]

In general, high costs and rapid and constant cost growth characterized the states' programs, especially in the areas of hospital care and some items originally thought to be relatively inexpensive, such as psychiatric hospital coverage. Expenditures, adjusted for inflation in medical prices, rose rapidly. For example, in Alaska, there was a 285-percent increase from 1978 to 1982; in Maine, an almost 500-percent increase from 1976 to 1981; in Minnesota, a 336-percent increase from 1979 to 1981. The

[2]The $250,000 limit applies to out-of-state psychiatric hospital care, which was a substantial part of Rhode Island's expense in this category.

states often had to reassess the relative costs and revenues of their programs and to control the use of services.

As a result of rapid growth in program costs, the states instituted initiatives or modified existing mechanisms to contain the use of services and overall costs. They used three basic cost-sharing mechanisms to control costs: (1) deductibles, (2) coinsurance payments, and (3) limits to coverage. It was important not only to have these mechanisms but also to revise them as information on program costs became available.

A deductible of either a set minimum amount or an amount based on a percentage of income, whichever was greater, was the most commonly used cost-sharing mechanism. For example, in Maine the set minimum was $7,000 plus 30 percent of net income and 10 percent of assets. In Minnesota, lower-income groups qualified when medical expenses reached 30 percent of income and higher-income groups qualified when expenses exceeded 50 percent of income.[3]

Rhode Island created explicit incentives to encourage its enrollees to carry other insurance coverage by basing a varying deductible on the quality of an applicant's insurance coverage: the more extensive the insurance coverage, the lower the deductible. This is the most unique and distinguishing feature of Rhode Island's program, which is the only program that has been able to maintain hospital benefits, the most costly benefit for the states to provide.

Coinsurance payments were used as a way of discouraging recipients from using "unnecessary" services. Minnesota required a 10-percent copayment from enrollees on all expenses.

In setting limits on coverage, several states reevaluated whether they would offer hospital benefits. Both Maine and New Hampshire discontinued hospital benefits because of high costs, New Hampshire after only one year. Minnesota's program had high hospital benefit costs and high projected program costs, including high hospital estimates, when the decision to close the program was made. Some states also limited other benefits, such as skilled nursing facilities and home health care. Alaska, for example, limited total coverage to $50,000 per case.

[3]These percentages were changed at different times. The low- and high-income percentages were 40 and 60 percent in 1977, were changed to 30 and 50 percent in 1979, and were changed to 20 and 30 percent in 1981.

The Administration of the State Programs

The programs were administered from within existing agencies, which caused some problems regarding relationships and priorities with respect to other established programs but helped keep the administrative costs of the programs down. The departments that administered the catastrophic illness programs all also administered the states' welfare services. This has been cited as a possible way of easing the access of the low-income and welfare population to services.

At least three states found an administrative problem with the eligibility determination process. Among the most difficult were the tasks of computing the point at which beneficiaries had "spent down" enough to qualify for Medicaid and determining which of the services claimed were covered by the program.

The experiences in the states—Alaska, Maine, and Rhode Island for at least a decade; New Hampshire for 6 years and Minnesota for 4—indicate their need for continual attention to ways in which current administrative structures could be used to implement a program and to identify and limit its costs. Administrative costs seem to be reduced to the extent that a program employs existing agencies and resources.

Summary of the States' Experience

Five states have had catastrophic illness programs at some time since the mid-1970's, and all had as their general goal protecting individuals and families from exceedingly large financial burdens from medical expenses. The experiences of Alaska, Maine, Massachusetts, Minnesota, and Rhode Island in attempting to meet this goal provide some useful information in regard to both things that worked well and those that did not. These lessons may be relevant to defining the structure of a national catastrophic illness insurance program.

First, each program served only a small proportion of a state's population. It is expected that programs based on the current federal legislation will also serve only a small proportion of the population. Further, the programs in some cases served populations for which benefits were not originally intended.

Second, all the programs experienced sizable cost growth, much of it unexpected. In all cases, hospital costs were the largest source of program expenditures. The control of cost growth was a major concern for all five states, and it was a major factor in the discontinuation of the programs in Alaska, Maine, and Minnesota.

Each state tried to control rising costs. The major approaches were the establishment of or an increase in (1) deductibles, (2) coinsurance payments, and (3) limits to coverage. In one particularly innovative instance, Rhode Island created explicit incentives to beneficiaries to carry other insurance coverage by basing the deductible on the amount of the applicants' insurance coverage. Rhode Island is also the only state that has maintained hospital benefits.

H.R. 2470 and S. 1127 cover some of the same services that were covered by the five state programs—most notably expanded hospital benefits. The federal bills also provide for deductibles and coinsurance, as did the state programs. However, the federal bills do not set limits for coverage. The lesson learned in this area is that the states had to reevaluate the benefits they covered and deductibles, coinsurance, and levels of limits in attempts to reduce cost growth.

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